Washington State Department of Social & Health Services

# Application for Pregnancy Medical Benefits

| | | | | |
|---|---|---|---|---|
| 1. FIRST NAME | MIDDLE INITIAL | LAST NAME | | |
| 2. ADDRESS WHERE YOU LIVE | STREET | CITY | STATE | ZIP CODE |
| 3. MAILING ADDRESS (IF DIFFERENT) | STREET | CITY | STATE | ZIP CODE |

4. PHONE NUMBERS / E-MAIL ADDRESS

HOME / CELL / PREFERRED NUMBER

WORK / MESSAGE

E-MAIL ADDRESS

5.

| | YES | NO |
|---|---|---|
| Do you have trouble speaking, reading or writing English? ..... | ☐ | ☐ |
| Do you need an interpreter? (If yes, we will communicate through an interpreter.)..... | ☐ | ☐ |

What language do you speak?

6. Expected date of delivery: _____ If unknown, please estimate: _____

How was pregnancy verified: ☐ Home pregnancy test ☐ Doctor ☐ Health department ☐ Other: _____

7. Does the pregnant woman have a medical condition which needs medical attention right away? ☐ Yes ☐ No

## General Information

8. List yourself and everyone living at your address. Use legal names. Do not use nicknames. If you do not know a Social Security Number, leave it blank.

| NAME (FIRST, MIDDLE,LAST) | SEX M or F | RELATION TO YOU | BIRTH DATE (MO/DA/YR) | SOCIAL SECURITY NUMBER | U.S. CITIZEN YES NO | PLACE OF BIRTH (CITY/STATE) | COMPLETE IF **NOT** A U.S. CITIZEN | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | LIST DATE ARRIVED IN U.S. | DO YOU HAVE A SPONSOR? YES NO |
| A. | | **SELF** | | | ☐ ☐ | | | ☐ ☐ |
| B. | | | | | ☐ ☐ | | | ☐ ☐ |
| C. | | | | | ☐ ☐ | | | ☐ ☐ |
| D. | | | | | ☐ ☐ | | | ☐ ☐ |
| E. | | | | | ☐ ☐ | | | ☐ ☐ |
| F. | | | | | ☐ ☐ | | | ☐ ☐ |

Please attach any documents showing immigration status.

## Health Insurance and Medical Information

9. Do you already have health insurance? ☐ Yes ☐ No If yes, we may be able to pay the premium.

If you checked "yes", list the name of your insurance company or employer, the policy number and the policy holder's name and social security number. Even if you already have health insurance, you can still qualify for medical benefits.

| INSURANCE COMPANY OR EMPLOYER | POLICY NUMBER | POLICY HOLDER'S NAME | POLICY HOLDER'S SSN |
|---|---|---|---|
| | | | |

10. Did anyone in the home receive medical services in the past three (3) months including Maternity Support Services and/or Maternity Case Management? ☐ Yes ☐ No



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## Income

| Your income from employment / self-employment | Spouse's income from employment / self-employment |
|---|---|
| 11. Employer name and phone number | 13. Employer name and phone number |
| 12. Gross income before taxes or expenses: _____<br>☐ Weekly ☐ Every two weeks ☐ Twice a month<br>☐ Monthly **Hours worked each week:** | 14. Gross income before taxes or expenses: _____<br>☐ Weekly ☐ Every two weeks ☐ Twice a month<br>☐ Monthly **Hours worked each week:** |

| OTHER INCOME | AMOUNT | HOW OFTEN DO YOU GET THIS INCOME? | WHICH FAMILY MEMBER GETS THIS INCOME? |
|---|---|---|---|
| 15. Child support or alimony | | | |
| 16. Social Security payment | | | |
| 17. Unemployment benefits | | | |
| 18. Veterans benefits/military allotments | | | |
| 19. Labor and Industries | | | |
| 20. Investment Income/other (explain): | | | |

## Expenses

| | YES | NO | IF YES, AMOUNT |
|---|---|---|---|
| 9. Do you pay for child care or adult dependent care while you work? | ☐ | ☐ | _____ |
| 10. Do you pay child support for a child who is not living in your home? | ☐ | ☐ | _____ |

## Race/Ethnic Background

We ask you to voluntarily tell us your race or ethnic background. This information will not be used in considering your eligibility for benefits.

☐ Caucasian ☐ Hispanic ☐ American Indian or Alaskan Native; tribe name: _____

☐ Vietnamese/Laotian/Cambodian ☐ Other Asian or Pacific Islander ☐ Other: _____

## *Read Carefully Before Signing Below*

I understand that:

- I must immediately report to the Department of Social and Health Services (DSHS), in writing or by telephone, any changes in my situation. Late reporting may cause incorrect benefits.
- My situation is subject to verification by DSHS or other state or federal agencies.
- I must provide proof I am eligible for help. DSHS may help me obtain the proof or contact other persons or agencies for it.
- By asking for and receiving medical care benefits, I assign to the state of Washington all rights to any medical support, and to any third party payments for medical care.
- DSHS may share my child's immunization history with the Department of Health's Child Profile Immunization Tracking System for purposes directly connected to the administration of medical programs.
- **I understand this application is for medical benefits for the pregnant woman only. If my family needs financial assistance or food stamps, we must apply through a DSHS Community Services Office.**

## Declaration and Signature

**I have read and understood the information in this application. I declare, under penalty of perjury, the information I have given in this application is true, correct, and complete to the best of my knowledge.**

SIGNATURE OF APPLICANT DATE

Discrimination is prohibited in all programs and activities administered by the Department of Social and Health Services. No one shall be excluded from these programs and activities on the basis of race, color, creed, political beliefs, national origin, religion, age, sex or disability.